

## Happenings

# **Aboriginal Health Human Resources Initiatives: Towards the Development of a Strategic Framework**

**Wendy McBride and David Gregory**

### **The Urgent Need for Aboriginal Health Human Resources**

Every province and territory in Canada is experiencing a shortage of health human resources (HHR). This shortage is also evident in Aboriginal communities and in the delivery of health services to Aboriginal people in urban centres. The Royal Commission on Aboriginal Peoples (1996) recommended that 10,000 health professionals be educated over the succeeding decade. In September 2004, following their annual meeting, the First Ministers announced a Pan-Canadian Health Human Resources Strategy with four main components: HHR Planning, Inter-professional Education for Collaborative Patient-Centred Practice, Recruitment and Retention, and Aboriginal HHR Issues. The HHR Strategy seeks to create a stable health-care workforce with an appropriate number and mix of health professionals as well as a renewed and revitalized health system that provides care to Canadians when they need it, regardless of their geographical location.

Because of the poor health indicators among Aboriginal peoples compared to the Canadian population at large, and because of particular issues related to the need for both Aboriginal and non-Aboriginal HHR, governments committed \$100 million to an Aboriginal Health Human Resources Initiative (AHHRI). Funding for the Strategy was agreed upon (at \$20 million annually) for a 5-year period commencing in 2003–04. The purpose of AHHRI is to

develop and implement a national Aboriginal Health Human Resources Strategy that will meet the needs of Aboriginal people, and respond to the current, new and emerging health services issues and priorities while integrating with the pan-Canadian HHR Strategy. (Health Canada, 2004)

A particular challenge for the initiative is meaningful involvement by Aboriginal organizations and communities in the development of relevant and effective strategies to increase the number of Aboriginal health professionals and para-professionals. Licensed and non-licensed workers include nurses (registered nurses, registered psychiatric nurses, licensed practical nurses), physicians, pharmacists, psychologists, health administrators, community mental health workers, community health representatives, and others concerned with the provision of health-care services to Aboriginal people.

With respect to nursing and the education of Aboriginal people, substantive consultations had been held over the preceding few years. As Executive Director of the Canadian Association of Schools of Nursing (CASN), Wendy McBride had directed projects for the First Nations and Inuit Health Branch (FNIHB) related to the education of nursing staff and acquisition of the clinical skills needed to work in Aboriginal communities. For example, CASN surveyed nursing schools regarding Aboriginal students, curriculum content related to nursing practice in Aboriginal communities, and supports available to Aboriginal students. McBride also chaired or co-chaired two national workshops on Aboriginal nursing education: the Aboriginal Nursing Education National Invitational Symposium (Canadian Association of Schools of Nursing, 2003), and the Aboriginal Nursing Education Symposium (Aboriginal Nurses Association of Canada, 2004).

David Gregory served as co-chair, with Fjola Wasakesikaw, of the 2002 FNIHB-sponsored Task Force on Aboriginal Nursing, which resulted in a comprehensive set of recommendations in the report *Against the Odds* (Health Canada, 2002). The recommendations addressed the need for systemic approaches to increasing the number of Aboriginal nurses in Canada. These collective experiences could be drawn on in developing strategies for the education of health professionals and para-professionals.

### **Developing a Strategic Framework for AHHRI**

As a first step, we interviewed FNIHB staff and reviewed documents prepared within FNIHB and Health Canada related to Aboriginal Health, the First Ministers meeting in September 2004, and presentations by FNIHB staff to Aboriginal national organizations. We also examined recent reports and strategies prepared by the National Aboriginal Health Organization (NAHO), reflecting consultations with the Assembly of First Nations (AFN), the Inuit Tapiriit Kanatami (ITK), and the Métis National Council (MNC), as well as the report on the Canada-Aboriginal Peoples Roundtable. In addition, Gregory attended a 2-day

session on Aboriginal HHR held in Winnipeg, organized by the Assembly of Manitoba Chiefs and arising out of the Romanow Joint Working Group.

Following the interviews and the review of documents and presentations, we determined that considerable thinking and planning had been undertaken by FNIHB, other branches within Health Canada, and Aboriginal organizations. There was congruence between the perspectives of government and those of Aboriginal people with regard to the challenges and opportunities presented in addressing the development of Aboriginal HHR. This congruence is reflected in AHHRI's three stated goals (Health Canada, 2004):

- to increase the number of Aboriginal health-care workers in the workforce
- to improve retention of health-care workers in Aboriginal communities, reduce staff turnover, and encourage Aboriginal health-care workers to practise within communities
- to adapt the present health professional curricula to reflect Aboriginal cultural and traditional needs and knowledge, in order to deliver optimal care to Aboriginal clients

It was also evident that "Aboriginal peoples," for AHHRI purposes, must include First Nations, Inuit, and Métis people whether living in isolated, remote, northern, rural, or urban communities. This is important, as there is an increasing trend for Aboriginal people to move among their communities and from more remote and rural areas to urban settings ("Life in the cities for aboriginal Canadians," 2005); therefore, any strategies and actions undertaken by and with Aboriginal people must include all three levels of government as well as Aboriginal governments and institutions.

The approach we took in conceptualizing a strategic framework was to first identify the main components of a strategy and the common commitment to AHHRI. The main components of a strategy are goals, priorities, actions, participants, partners, and resources, while an essential element in ensuring the success of any strategy is commitment. The commitment of Aboriginal organizations to improving the health status of their people and communities, through the development and involvement of their own health-care providers, can be found in the *Report of the Royal Commission on Aboriginal Peoples* (Royal Commission on Aboriginal Peoples, 1996), *Against the Odds: Aboriginal Nursing* (Health Canada, 2002), the reports on the Aboriginal Nursing Education Workshops held in 2003 and 2004 (Aboriginal Nurses Association of Canada, 2004; Canadian Association of Schools of Nursing, 2003), and the *Strategic Framework* presented to FNIHB by NAHO (2005). Commitment by the federal,

provincial, and territorial governments is expressed in the Health Accord (Health Canada, 2003), the Pan-Canadian Health Human Resources Strategy (First Ministers, 2004), and the First Ministers and Aboriginal Leaders Meeting (First Ministers, 2004).

### National Strategy Session

FNIHB identified the need for a national strategy session in relation to AHHRI. The agenda for this session was planned with a view to allowing maximum time to hear from Aboriginal organizations about priorities and challenges associated with developing HHR. It was also designed to solicit input from the representatives of national Aboriginal organizations with regard to an action framework. The meeting room was arranged as an “inner circle” of participants from the national Aboriginal organizations<sup>1</sup> and an “outer circle” of observers from the federal, provincial, and territorial governments as well as other invited guests.

NAHO was invited to present the strategies it had envisioned for HHR development as a result of its consultations with national Aboriginal organizations. A panel of representatives of five national Aboriginal organizations (AFN, ITK, MNC, CAP, and NWAC) and NAHO was formed to comment on the NAHO strategies and to present the priorities identified by each organization. In addition, three speakers were invited to give presentations on the postsecondary education of Aboriginal students. These were Peter Nunoda, Director, ACCESS, University of Manitoba, speaking on “ACCESS Programs and Best Practices for Aboriginal HHR Development”; David Gregory, Professor, Faculty of Nursing, University of Manitoba, speaking on “Against the Odds: Aboriginal Nursing”; and Lindsay Crowshoe, Assistant Professor, Faculty of Medicine, University of Calgary, speaking on

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<sup>1</sup> The following national Aboriginal organizations participated in the strategy session: Aboriginal Institutes Consortium (AIC), Aboriginal Nurses Association of Canada (ANAC), Aboriginal Telehealth Knowledge Circle, Assembly of First Nations (AFN), Canadian Aboriginal Nutritionists Network (CANN), Congress of Aboriginal Peoples (CAP), Inuit Tapiriit Kanatami (ITK), Labrador Inuit Health Commission (LIHC), Métis National Council (MNC), National Aboriginal Achievement Foundation (NAAF), National Aboriginal Health Organization (NAHO), National Aboriginal Health Organization – Ajuunginiq Centre, National Indian and Inuit Community Health Representatives Organization (NIICHO), National Native Addictions Partnership Foundation (NNAPF), Native Mental Health Association of Canada (NMHAC), Native Women’s Association of Canada (NWAC), and Aboriginal Human Resource Development Council of Canada (AHRDCC). The FNIHB also extended invitations to provincial and territorial governments, the Canadian Institute for Health Research (CIHR), First Nations University of Canada, other federal departments (INAC, HRSDC), and relevant directorates within Health Canada.

“Cultural Competence.”

Building on *Against the Odds* (Health Canada, 2002), we encouraged participants to reflect on specific areas requiring investment in future generations. These are points of vulnerability along the path that most future Aboriginal health-care workers will take. The areas were considered in four stages along the continuum of health-care education and practice: Upstream, Transitions, Access and Admission to Education and Practice, and Future Practice. While not exhaustive, these points are illustrative of the changes needed to increase the presence of Aboriginal people in regulated and non-regulated health professions. The four stages are outlined as follows:

- **Upstream.** Improving basic education (K-12) with an emphasis on science, mathematics, English, and literacy; high-school completion and the support needed by students from their parents and communities; marketing of health careers to Aboriginal people through role models and recruitment information on health-care education
- **Transitions: high-school completion and admissibility to colleges and universities.** Preparatory or transition programs offered by colleges and universities
- **Access and admission to education and practice.** Entrance requirements that are receptive to Aboriginal students; preparatory programs and supports; student supports such as those provided through Native ACCESS programs; practicum opportunities for Aboriginal and non-Aboriginal students in Aboriginal communities; mentors, role models, counsellors, and elders; adequate funding support for Aboriginal students during their education; preparation for examinations and licensing requirements; employment search support
- **Future practice.** Continued mentoring and advice; continuing education to develop/maintain knowledge; skills upgrading to advance education levels; additional certification to recognize advanced skills and experience; support for laddering to other education levels; healthy, supportive, culturally appropriate workplaces.

### **The Next Steps**

It is anticipated that further discussions will take place in various regions, provinces, and territories over the next year, to engage and involve Aboriginal organizations and communities in actualizing AHHRI. There will be opportunities for academics and researchers to become involved in the support of Aboriginal groups, institutions, and communities. As noted in *An Environmental Scan of Current Views on Health Human Resources in Canada* (El-Jardali & Fooks, 2005), Aboriginal organizations

continue to perceive a lack of Aboriginal and non-Aboriginal HHR as well as a need for culturally competent health care. Data are required on supply and demand as well as on the specific needs of different Aboriginal populations, locations, and communities. Nurse academics and researchers are encouraged to become more aware of the needs and aspirations of Aboriginal students, communities, and practitioners, and to become involved in new approaches to nursing education to meet those needs.

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